

**TRANSMITTAL AND NOTICE OF APPROVAL OF  
STATE PLAN MATERIAL**  
FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: <u>0 2 — 0 0 9</u>	2. STATE: <b>Arkansas</b>
3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)	
4. PROPOSED EFFECTIVE DATE <b>April 1, 2002</b>	

TO: REGIONAL ADMINISTRATOR  
HEALTH CARE FINANCING ADMINISTRATION  
DEPARTMENT OF HEALTH AND HUMAN SERVICES

5. TYPE OF PLAN MATERIAL (Check One):

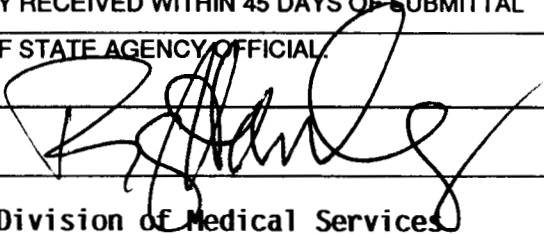
☐ NEW STATE PLAN      ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN      ☒ AMENDMENT

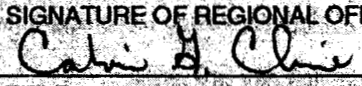
COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT (Separate Transmittal for each amendment)

6. FEDERAL STATUTE/REGULATION CITATION: <b>42 CFR 440.70(b)(3)</b>	7. FEDERAL BUDGET IMPACT: a. FFY <u>2002</u> \$ <u>-0-</u> b. FFY <u>2003</u> \$ <u>-0-</u>
8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:  <b>Please see attached listing</b>	9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT (If Applicable):  <b>Please see attached listing</b>

10. SUBJECT OF AMENDMENT:  
**The Arkansas Title XIX State Plan has been amended to move medical supplies and equipment items from the Prosthetics category to the Home Health category. (See HCFA letter reference ME-17-0-1 & ME-41-5-1).**

11. GOVERNOR'S REVIEW (Check One):  
☒ GOVERNOR'S OFFICE REPORTED NO COMMENT      ☐ OTHER, AS SPECIFIED:  
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED  
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL

12. SIGNATURE OF STATE AGENCY OFFICIAL: 	16. RETURN TO: Division of Medical Services P. O. Box 1437 Little Rock, AR 72203-1437  Attention: Binnie Alberius Slot S295
13. TYPED NAME: <b>Ray Hanley</b>	
14. TITLE: <b>Director, Division of Medical Services</b>	
15. DATE SUBMITTED: <b>March 15, 2002</b>	

<b>FOR REGIONAL OFFICE USE ONLY</b>	
17. DATE RECEIVED: <b>18 MARCH 2002</b>	18. DATE APPROVED: <b>15 APRIL 2002</b>
<b>PLAN APPROVED - ONE COPY ATTACHED</b>	
19. EFFECTIVE DATE OF APPROVED MATERIAL: <b>1 APRIL 2002</b>	20. SIGNATURE OF REGIONAL OFFICIAL: 
21. TYPED NAME: <b>CALVIN G. CLINE</b>	22. TITLE: <b>ASSOCIATE REGIONAL ADMINISTRATOR DIV OF MEDICAID AND STATE OPERATIONS</b>

23. REMARKS:

**ATTACHED LISTING FOR  
ARKANSAS STATE PLAN  
TRANSMITTAL #2002-009**

**8. Number of the Plan  
Section or Attachment**

Attachment 3.1-A, Page 3c

Attachment 3.1-A, Page 3d

Attachment 3.1-A, Page 5c

Attachment 3.1-B, Page 3e

Attachment 3.1-B, Page 3f

Attachment 3.1-B, Page 5b

Attachment 4.19-B, Page 1j

Attachment 4.19-B, Page 1k

Attachment 4.19-B, Page 2c

Attachment 4.19-B, Page 2d

Attachment 4.19-B, Page 2e

Attachment 4.19-B, Page 2f

**9. Number of the Superseded Plan  
Section or Attachment**

Attachment 3.1-A, Page 3c  
Approved 01-29-02, TN 01-37;  
Attachment 3.1-A, Page 5c  
Approved 07-24-97, TN 97-08

Attachment 3.1-A, Page 3d  
Approved 08-03-01, TN 01-15

Attachment 3.1-A, Page 5cc  
Approved 02-04-00, TN 99-26

Attachment 3.1-B, Page 3e,  
Approved 01-29-02, TN 01-37;  
Attachment 3.1-B, Page 5a  
Approved 12-20-01, TN 01-39 and  
Attachment 3.1-B, Page 5b  
Approved 07-24-97, TN 97-08

Attachment 3.1-B, Page 3f  
Approved 08-03-01, TN 01-15

Attachment 3.1-B, Page 5bb  
Approved 02-04-00, TN 99-26

Attachment 4.19-B, Page 1j  
Approved 12-20-01, TN 01-39

Attachment 4.19-B, Page 1k  
Approved 07-24-97, TN 97-08

Attachment 4.19-B, Page 2c  
Approved 02-12-01, TN 00-16

Attachment 4.19-B, Page 2d  
Approved 02-12-01, TN 00-16 and  
Attachment 4.19-B, Page 4e, Item (10)  
Approved 09-09-97, TN 97-09

Attachment 4.19-B, Page 4d  
Approved 02-11-91, TN 91-02

Attachment 4.19-B, Page 4e, Item (7) and  
Item (8), Approved 09-09-97, TN 97-09

**8. Number of the Plan  
Section or Attachment**

Attachment 4.19-B, Page 2g

Attachment 4.19-B, Page 2h

Attachment 4.19-B, Page 2i

Attachment 4.19-B, Page 4b

Attachment 4.19-B, Page 4c

Attachment 4.19-B, Page 5

Attachment 4.19-B, Page 5a

Attachment 4.19-B, Page 5b

**9. Number of the Superseded Plan  
Section or Attachment**

Attachment 4.19-B, Page 4e, Item (9),  
Approved 09-09-97, TN 97-09 and  
Page 5, Item (11), Approved 07-24-97,  
TN 97-08

Attachment 4.19-B, Page 5, Item (12)  
Approved 07-24-97, TN 97-08  
and Page 5a, Item (13)  
Approved 02-04-00, TN 99-26

None, New Page

Attachment 4.19-B, Page 4b, Items c.(1)  
thru (4), Approved 06-30-93, TN 92-28  
and Page 4d, Item (6), Approved 02-11-91,  
TN 91-02

Attachment 4.19-B, Page 5aa, Item (14)  
Approved 11-16-01, TN 01-32

Attachment 4.19-B, Page 5aaa,  
Pending Approval, TN 01-42

Attachment 4.19-B, Page 5b  
Approved 12-18-95, TN 95-24

Attachment 4.19-B, Page 5c  
Approved 02-22-95, TN 95-01

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
Page 3c

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

CATEGORICALLY NEEDY

- 7.a. Home Health Services
- 7.b. Based on a physician's prescription as to medical necessity provided to eligible recipients at their place of residence not to include institutions required to provide these services. For services above 25 visits per recipient per State Fiscal Year, the provider must request an extension. Extension of the benefit limit will be provided for all recipients, including EPSDT, if determined medically necessary.
- 7.c. Medical supplies, equipment, and appliances suitable for use in the home.
- (1) Medical supplies are covered for eligible Medicaid recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home (Home does not include a long term care facility.) Supplies are limited to a maximum reimbursement of \$250.00 per month, per recipient. As medical supplies are provided to recipients through the Home Health Program and the Prosthetics Program, the maximum reimbursement of \$250.00 per month may be provided through either program or a combination of the two. However, a recipient may not receive more than \$250.00 in supplies whether received through either of the two programs or a combination of the two unless an extension has been granted. Extensions will be considered for recipients under age 21 in the Child Health Services (EPSDT) Program if documentation verifies medical necessity. The provider must request an extension of the established benefit limit.
- (2) Durable Medical Equipment (DME) - Services are covered in the recipient's home if prescribed by the recipient's physician as medically necessary. Some DME requires prior authorization. DME is limited to specific items. Specific DME is listed in Section III of the Prosthetics Provider Manual.
- (3) Augmentative Communication Device
- Services for recipients under age 21 are covered as a result of a Child Health Services (EPSDT) screening/referral. Services for recipients over age 21 are covered if prescribed by the recipient's physician as medically necessary. Prior authorization is required.
- (4) Specialized Wheelchairs
- Specialized Wheelchairs are provided for eligible recipients of all ages if prescribed by the recipient's physician as medically necessary. Prior authorization is required for some items. These items are listed in Section III of the Prosthetics Provider Manual.

SUPERSEDES: TN- AR 01-37

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SUPERSEDES: TN- AR 97-08 (pg. 5c)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
Page 3d

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

CATEGORICALLY NEEDY

7. Home Health Services (Continued)

7.c. Medical supplies, equipment, and appliances suitable for use in the home. (Continued)

(5) Diapers/Underpads

Diapers/underpads are limited to \$130.00 per month, per recipient. The \$130.00 benefit limit is a combined limit for diapers/underpads provided through the Prosthetics Program and Home Health Program. The benefit limit may be extended with proper documentation. Only patients with a medical diagnosis other than infancy which results in incontinence of the bladder and/or bowel may receive diapers. This coverage does not apply to infants who would otherwise be in diapers regardless of their medical condition. Providers can not bill for underpads/diapers if a recipient is under the age of three years.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitative facility.

Services under this item are limited to physical therapy when provided by a home health agency and prescribed by a physician. Effective for dates of service on or after October 1, 1999, individual and group physical therapy are limited to four (4) units per day. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. Extensions of the benefit limits will be provided if medically necessary for eligible Medicaid recipients under age 21.

8. Private Duty Nursing Services

Services are covered only for ventilator-dependent recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home, a Division of Developmental Disabilities (DDS) community provider facility or a public school. (Home does not include an institution.) Prior authorization is required. Private duty nursing medical supplies are limited to a maximum reimbursement of \$80.00 per month, per recipient. With substantiation, the maximum reimbursement may be extended.

Refer to Attachment 3.1-A, Item 4.b.(5) for information on coverage of private duty nursing services for high technology non-ventilator dependent recipients in the Child Health Services (EPSDT) Program.

SUPERSEDES: TN- AR 01-15

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-A  
Page 5c

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

CATEGORICALLY NEEDY

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(5) Orthotic Appliances

**Services for recipients under age 21 are not benefit limited.**

Services for recipients age 21 and over are limited to \$3,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for an orthotic appliance is \$500 or more, prior authorization is required. Specific covered orthotic appliances are listed in Section III of the Prosthetics Provider Manual.

(6) Prosthetic Devices

**Services for recipients under age 21 are not benefit limited.**

Services for recipients age 21 and over are limited to \$20,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for a prosthetic device is \$1,000 or more, prior authorization is required. Specific covered prosthetic devices are listed in Section III of the Prosthetics Provider Manual.

SUPERSEDES: TN- AR 99-26 (pg 5cc)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>07-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 3e

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

MEDICALLY NEEDY

- 7.a. Home Health Services
- 7.b. Based on a physician's prescription as to medical necessity provided to eligible recipients at their place of residence not to include institutions required to provide these services. For services above 25 visits per recipient per State Fiscal Year, the provider must request an extension. Extension of the benefit limit will be provided for all recipients, including EPSDT, if determined medically necessary.
- 7.c. Medical supplies, equipment, and appliances suitable for use in the home.
- (1) Medical supplies are covered for eligible Medicaid recipients when determined medically necessary and prescribed by a physician. Services are provided in the recipient's home (Home does not include a long term care facility.) Supplies are limited to a maximum reimbursement of \$250.00 per month, per recipient. As medical supplies are provided to recipients through the Home Health Program and the Prosthetics Program, the maximum reimbursement of \$250.00 per month may be provided through either program or a combination of the two. However, a recipient may not receive more than \$250.00 in supplies whether received through either of the two programs or a combination of the two unless an extension has been granted. Extensions will be considered for recipients under age 21 in the Child Health Services (EPSDT) Program if documentation verifies medical necessity. The provider must request an extension of the established benefit limit.
- (2) Durable Medical Equipment (DME) - Services are covered in the recipient's home if prescribed by the recipient's physician as medically necessary. Some DME requires prior authorization. DME is limited to specific items. Specific DME is listed in Section III of the Prosthetics Provider Manual.
- (3) Augmentative Communication Device
- Services for recipients under age 21 are covered as a result of a Child Health Services (EPSDT) screening/referral. Services for recipients over age 21 are covered if prescribed by the recipient's physician as medically necessary. Prior authorization is required.
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SUPERSEDES: TN- AR 01-37

SUPERSEDES: TN- AR 01-39 (pg. 5a)

SUPERSEDES: TN- AR 97-08 (pg. 5b)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 3f

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

MEDICALLY NEEDY

7. Home Health Services (Continued)

7.c. Medical supplies, equipment, and appliances suitable for use in the home. (Continued)

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Diapers/underpads are limited to \$130.00 per month, per recipient. The \$130.00 benefit limit is a combined limit for diapers/underpads provided through the Prosthetics Program and Home Health Program. The benefit limit may be extended with proper documentation. Only patients with a medical diagnosis other than infancy which results in incontinence of the bladder and/or bowel may receive diapers. This coverage does not apply to infants who would otherwise be in diapers regardless of their medical condition. Providers can not bill for underpads/diapers if a recipient is under the age of three years.

7.d. Physical therapy, occupational therapy, or speech pathology and audiology services provided by a home health agency or medical rehabilitative facility.

Services under this item are limited to physical therapy when provided by a home health agency and prescribed by a physician. Effective for dates of service on or after October 1, 1999, individual and group physical therapy are limited to four (4) units per day. One unit equals 15 minutes. Evaluations are limited to four (4) units per State Fiscal Year (July 1 through June 30). One unit equals 30 minutes. Extensions of the benefit limit will be provided if medically necessary for eligible Medicaid recipients under age 21.

SUPERSEDES: TN- AR 01-15

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APP'VD <u>04-15-02</u>	
DATE EFF <u>07-01-02</u>	
HCFA 179 <u>AR 02-09</u>	



STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 3.1-B  
Page 5b

AMOUNT, DURATION AND SCOPE OF  
SERVICES PROVIDED

Revised: April 1, 2002

MEDICALLY NEEDY

12. Prescribed drugs, dentures and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (Continued)

(5) Orthotic Appliances

**Services for recipients under age 21 are not benefit limited.**

Services for recipients age 21 and over are limited to \$3,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for an orthotic appliance is \$500 or more, prior authorization is required. Specific covered orthotic appliances are listed in Section III of the Prosthetics Provider Manual.

(6) Prosthetic Devices

**Services for recipients under age 21 are not benefit limited.**

Services for recipients age 21 and over are limited to \$20,000 per State Fiscal Year (July 1 through June 30). When the Medicaid maximum allowable for a prosthetic device is \$1,000 or more, prior authorization is required. Specific covered prosthetic devices are listed in Section III of the Prosthetics Provider Manual.

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

SUPERSEDES TN- AR 99-26 (pg. 566)

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 1j

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of Conditions Found. (Continued)

- (8) The following services that are not otherwise covered under the Arkansas State Plan will be reimbursed when provided as a result of a Child Health Services (EPSDT) screening/referral (Continued):

b. Respiratory Care Services

Respiratory Therapy Services for Ventilator-Dependent

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum was established based on a 1990 survey of three Arkansas durable medical companies who employ respiratory therapists. The rate was established by using the median rate obtained by the DME companies.

Effective for claims with dates of service on or after July 1, 1992, the Title XIX maximum rate was decreased by 20%.

SUPERSEDES: TN- AR 01-39

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-03</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 1k

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

4.b. Early and Periodic Screening and Diagnosis of Individuals Under 21 Years of Age and Treatment of  
Conditions Found. (Continued)

- (8) The following services that are not otherwise covered under the Arkansas State Plan will be  
reimbursed when provided as a result of a Child Health Services (EPSDT) screening/referral  
(Continued):

c. Services of Christian Science Nurses

Christian Science nurses are not licensed to practice in the State.

d. Care and Services Provided in Christian Science Sanatoria

There are no Christian Science Sanatoria facilities in the State.

SUPERSEDES: TN- AR 97-08

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 2c

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

6.d. Other Practitioner's Services (Continued)

(5) Psychologist Services

Refer to Attachment 4.19-B, Item 4.b. (17).

(6) Obstetric-Gynecologic and Gerontological Nurse Practitioner Services

Reimbursement is the lower of the amount billed or the Title XIX maximum allowable.

The Title XIX maximum is based on 80% of the physician fee schedule except EPSDT procedure codes. Medicaid maximum allowables are the same for all EPSDT providers. Immunizations and Rhogam RhoD Immune Globulin are reimbursed at the same rate as the physician rate since the cost and administration of the drug does not vary between the nurse practitioner and physician.

Refer to Attachment 4.19-B, Item 27, for a list of the nurse practitioner pediatric and obstetrical procedure codes.

7. Home Health Services

- a. Intermittent or part-time nursing services furnished by a home health agency or a registered nurse when no home health agency exists in the area; and
- b. Home health aide services provided by a home health agency

Reimbursement on basis of amount billed not to exceed the Title XIX (Medicaid) maximum.

The initial computation (effective July 1, 1994) or the Medicaid maximum for home health reimbursement was calculated using audited 1990 Medicare cost reports for three high volume Medicaid providers, Medical Personnel Pool, Arkansas Home Health, W. M. and the Visiting Nurses Association. For each provider, the cost per visit for each home health service listed above in items 7.a. and b. was established by dividing total allowable costs by total visits. This figure was then inflated by the Home Health Market Basket Index in Federal Register #129, Vol. 58 dated July 8, 1993- inflation factors: 1991 - 105.7%, 1992 - 104.1%, 1993 - 104.8%. The inflated cost per visit was then weighted by the total visits per providers' fiscal year (i.e., the visits reported on the 1990 Medicare cost reports) to arrive at a weighted average visit cost.

SUPERSEDES TN- AR 00-16

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 170 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 2d

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

7. Home Health Services (Continued)  
a. and b. (Continued)

For registered nurses (RN) and licensed practical nurses (LPN) the Full Time Equivalent Employees (FTEs) listed on cost report worksheet S-1, Part II, were used to allocate nursing costs and units of service (visits). It was necessary to make these allocations because home health agencies are not required by Medicare to separate their registered nurses and licensed practical nurse costs or visits on the annual cost report.

RN and LPN salaries and fringes were separated using an Office of Personnel Management Survey, which indicated that RNs, on an average, are paid 36% more than licensed practical nurses. Conversely, if RNs are paid 36% more than LPNs, then LPNs are paid, on an average, 73.5% of what RNs earn. Cost report salaries and fringes were allocated based on 100% of RN FTEs and 73.5% of LPN FTEs. Other costs and service units (visits) were allocated based on 100% of RN FTEs and 100% of LPN FTEs. RN and LPN unit service (visit) costs were then inflated and weighted as outlined above.

Since home health reimbursement is based on audited costs, the home health rates will be adjusted annually by the Home Health Market Basket Index. This adjustment will occur at the beginning of the State Fiscal Year, July 1. Every third year, the cost per visit will be rebased utilizing the most current audited cost report from the same three providers and using the same formula described above to arrive at a cost per visit inflated through the rebasing year. (The first rebasing will occur in 1996 to be effective July 1, 1997.)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home

(1) Medical Supplies

Effective for dates of service on or after October 1, 1994, medical supplies, for use by patient in their own home - Reimbursement is based on 100% of the Medicare maximum for medical supplies reflected in the 1993 Arkansas Medicare Pricing File not to exceed the Title XIX coverage limitations as specified in Attachment 3.1-A and Attachment 3.1-B, Item 12.c.7.

SUPERSEDES: TN- AR 00-16  
+

SUPERSEDES: TN- AR 97-09 (page Item 10)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HGFA 170 <u>AR 02-09</u>	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

April 1, 2002

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

- (2) Durable Medical Equipment (DME) - Reimbursement is based on amount billed not to exceed the Title XIX maximum.

Purchase: The Title XIX maximum for new equipment is based on Medicare's 1990 DME Fee Schedule. For those items which Medicare did not have a rate, the lowest manufacturer cost plus 10% was used. Arkansas Medicaid is following Medicare's policy of purchasing any item that costs \$150.00 or less.

Rental/Capped Rental: Capped Rental equipment may not be rented for more than 455 consecutive days. The reimbursement rates for capped rental items will be established by dividing the purchase price by 455 days to arrive at a daily rental rate. Once the 455 day rental maximum is reached, Arkansas Medicaid will cease to pay rent on the equipment, however the equipment will remain in the recipient's home as long as determined medically necessary by the recipient's physician. The equipment will remain the property of the DME company.

A provider may bill for maintenance, however, this maintenance fee may not be billed until either 182 days have elapsed after the 455 day rental period or 182 days have elapsed from the end of the period the item is no longer covered under the suppliers or manufacturer's warranty, whichever is later. Maintenance will continue to be paid at six-month intervals if equipment is determined to be medically necessary. Reimbursement of the maintenance is the lesser of the amount billed or the Title XIX maximum. The Title XIX maximum was established by arraying all the Title XIX monthly maximums for capped rental items and utilizing the 50<sup>th</sup> percentile.

For those items which are rental only, the Medicare 1990 DME Fee Schedule monthly rental rate was used to calculate the Medicaid daily rental rate. The Medicare monthly rental rate was multiplied by 12 to determine the one year rental amount and divided by 365 to arrive at the Medicaid daily rental amount.

SUPERSEDES: TN- AR 91-02 (pg. 4d)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 2f

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

April 1, 2002

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(3) DME/Nasal CPAP Device

DME/Nasal CPAP Device - Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum was established based on a 1989 survey conducted by the Division of Medical Services of four Arkansas durable medical equipment companies. Reimbursement for the nasal CPAP device is always on a rental basis only. The rate was established by utilizing the lowest monthly rental rate reflected by the survey. The reimbursement methodology includes a provision for automatic adjustments based on fluctuations in the economy.

(4) DME/Bi-Level Positive Airway Pressure (BIPAP) Equipment

Effective for claims with dates of service on or after February 1, 1995, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX maximum for the BIPAP is based on 100% of the Medicare maximum for equipment and supplies reflected in the 1994 Arkansas Medicare Pricing File. The Medicaid monthly rental rate for equipment was used to calculate the daily rental rate. The BIPAP medical supply rate was established at 25% of the total for all supplies utilized with the BIPAP equipment. Reimbursement is a global rate for equipment, supplies and maintenance.

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

SUPERSEDES: TN- AR 97-09 (p. 4e Items 7+8)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

April 1, 2002

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(5) Aerochamber Device

Effective for dates of service on or after October 1, 1997, reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. The Title XIX (Medicaid) maximum established was based on a 1997 survey of Durable Medical Equipment (DME) providers. The information obtained in the survey indicated there is only one major manufacturer and distributor of the aerochamber devices (with or without mask) to providers enrolled in the Arkansas Medicaid Program. It was determined the aerochamber devices are sold to each provider for the same price. As a result, the current Title XIX (Medicaid) maximum for the aerochamber devices (with or without mask) was established based on the actual manufacturer's list prices. Thereafter, adjustments will be made based on the consumer price index factor to be implemented at the beginning of the appropriate State Fiscal Year, July 1.

(6) Specialized Wheelchairs, Seating and Rehab Items

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) maximum. Effective for claims with dates of service on or after May 1, 1995, the Title XIX (Medicaid) maximums were established utilizing the manufacturer's current published suggested retail price less 15%. The 15% is the median of Oklahoma Medicaid which is currently retail less 12% and Texas Medicaid which is currently retail less 18%. Effective for claims with dates of service on or after September 1, 1995, the following Kaye Products, procedure codes Z2059, Z2060, Z2061 and Z2062, are reimbursed at the manufacturer's current published suggested retail price. The State Agency and affected provider association representatives will review the rates annually and negotiate any adjustments.

SUPERSEDES: TN- AR 97-09 (pg. 4e Item 9)

SUPERSEDES: TN- AR 97-08 (pg. 5 Item 11)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	



METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

April 1, 2002

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(7) Augmentative Communication Device

Reimbursement is based on the manufacturer's charges. Providers must submit an itemized manufacturer's invoice with the claim. Reimbursement will include the cost of the device, software, carrying case and maintenance agreement, not to exceed a maximum of \$7,500.00. If a recipient under age 21 in the Child Health Services (EPSDT) Program has met the lifetime benefit, and it is determined that additional equipment is medically necessary, the provider can request an extension of benefits. Training in the use of the device is not included and is not a covered cost. Repairs to the equipment or associated items outside the initial maintenance agreement are a covered service. Reimbursement for repairs of augmentative communication device components will be manufacturer's invoice price for parts plus 10%. Arkansas Medicaid reimburses for the labor based on the lesser of the amount billed not to exceed the Title XIX (Medicaid) maximum. The Medicaid maximum was calculated by conducting a survey of three manufacturers of augmentative communication devices who repair state-of-the art devices to the less complex devices. The three manufacturer's current hourly charge for labor was totaled, then divided by 3 to arrive at an average hourly rate. The hourly rate was divided by 4 to arrive at a 15 unit rate. Labor will be reimbursed per unit of service, (1 unit = 15 minutes limited to a maximum of 20 units per date of service allowed).

(8) Phototherapy (Bili-rubin) Light with Polometer

Effective for dates on or after May 1, 1999, the reimbursement rate is based on the lesser of the provider's actual charge for the service or the Title XIX maximum. The Title XIX (Medicaid) maximum was based on 100% of the Medicare maximum (daily rental rate) for the Phototherapy (Bili-rubin) Light with Polometer as reflected in the 1999 Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule. The reimbursement methodology includes a provision allowing adjustments based on fluctuations in the economy. Any adjustment to the rate will be based on the most current Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule.

d. Physical Therapy

Refer to Item 4.b.(19).

SUPERSEDES: TN- AR 97-08 (pg. 5 Item 12)

SUPERSEDES: TN- AR 99-26 (pg. 5a Item 13)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

April 1, 2002

7. Home Health Services (Continued)

c. Medical Supplies, Equipment and Appliances Suitable for Use in the Home (continued)

(9) Oxygen

Reimbursement is based on the lower of the amount billed or the Title XIX maximum charge allowed.

The Title XIX maximum for the oxygen concentrator, liquid oxygen, liquid oxygen walker and reservoir is based on the DME fiscal year 1981 Medicare Median.

(10) Diapers

Reimbursement is based on the lesser of the provider's actual charge for the service or the Title XIX (Medicaid) Maximum. Effective March 1, 1991, the Medicaid Maximum was established based on the median cost for each item. The median cost was determined by surveying three medical supply companies.

SUPERSEDES: NONE - NEW PAGE

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 4b

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

b. Dentures

Refer to Attachment 4.19-B, Item 4.b.(9).

c. Prosthetic Devices

- (1) Eye Prostheses - Refer to Attachment 4.19-B, Item 4.b.(13).
- (2) Hearing Aids - Refer to Attachment 4.19-B, Item 4.b.(12).
- (3) Ear Molds - Refer to Attachment 4.19-B, Item 4.b.(14).
- (4) Pacemakers and Internal Surgical Prostheses - Reimbursed at 80% of invoice price.
- (5) Hyperalimentation - Reimbursement according to the lower of the amount billed or the Title XIX maximum charge allowed.

SUPERSEDES: TN- AR 92-18 (pg 9b Items 1-4)

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SUPERSEDES: TN- AR 91-03 (pg. 4d Item 6)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 4c

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)

c. Prosthetic Devices (continued)

(6) Orthotic Appliances and Prosthetic Devices

For Medicaid eligible recipients under age 21, the reimbursement methodology for orthotic appliances and prosthetic devices is based on amount billed not to exceed the Title XIX Maximum. The Title XIX Maximum is based on the Medicare Fiscal Year 1990 DME fee schedule.

For Medicaid eligible recipients age 21 and over the reimbursement is based on the lesser of the provider's actual charge for the services or the Title XIX (Medicaid) Maximum. The Title XIX (Medicaid) Maximum is based on the 1999 Medicare DME, Prosthetics, Orthotics and Supplies Fee Schedule less 18%.

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

SUPERSEDES: TN- AR 01-32 (pg. 5a4 Item 14)

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist (Continued)
- d. Eyeglasses
- Negotiated statewide contract bid.
13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)
- a. Diagnostic Services - Not provided.
- b. Screening Services - Not provided.
- c. Preventive Services - Not provided.
- d. Rehabilitative Services

1. Rehabilitative Services for Persons with Mental Illness

Reimbursement is based on the lower of the amount billed or the Title XIX (Medicaid) maximum allowable.

The Title XIX maximum was established based on a survey by the Division of Mental Health of the usual and customary charges used by community based programs. Rates include the professional and administrative components.

For acute outpatient services and acute day treatment previously found in the Mental Health Clinic option, reimbursement is based on the lower of: (a) the provider's actual charge for the services or (b) the allowable fee from the State's fee schedule based on average cost. The average cost of each mental health service was calculated based on 1978 cost data. A 20 per cent inflation factor was applied to arrive at the "fee schedule" rate.

Effective April 1, 1988, reimbursement rates were increased 78% to reflect rates comparable to those charges found in the private sector for comparable mental health services. Effective July 1, 1991, a 20% increase was applied.

Effective for dates of service on or after December 1, 2001, reimbursement for inpatient visits in acute care hospitals by board certified psychiatrists is based on 66% of the Physician's Blue Shield Fee Schedule dated October 1, 1993.

Effective for claims with dates of service on or after March 1, 2002, Arkansas State Operated Teaching Hospital psychiatric clinics that are not part of a hospital outpatient department shall be reimbursed based on reasonable costs with interim payments and a year-end cost settlement. The lesser of reasonable costs or customary charges will be used to establish cost settlements.

SUPERSEDES: TN- AR 01-72 (pg 5aaa)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APP'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 5a

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

13. Other diagnostic, screening, preventive and rehabilitative services, i.e., other than those provided elsewhere in this plan. (Continued)

d. Rehabilitative Services

2. Extended Rehabilitative Services for Persons with Physical Disabilities (RSPD)

a. Arkansas Non-State Operated Rehabilitative Hospitals

Refer to Attachment 4.19-A, Page 9a, for the reimbursement methodology, except no room and board charges will be reimbursed and the upper limit is set annually at the 70th percentile of all non-state operated rehabilitative hospitals' inflation-adjusted Medicaid per diem rate.

b. Arkansas State-Operated Rehabilitative Hospitals

Effective for claims with dates of service on or after 1-1-96, Arkansas State Operated Rehabilitative Hospitals are classified as a separate class group. The Medicaid definition of a state operated rehabilitative hospital is: A hospital that is recognized as a state operated rehabilitative facility.

The per diem reimbursement for Rehabilitative Services for Persons with Physical Disabilities (RSPD) provided by a State Operated Rehabilitative Hospital will be in accordance with the reimbursement methodology in Attachment 4.19-A, Page 9a, except; the initial per diem rate will be capped at \$232.00, no room and board charges will be reimbursed and the annual inflation factor will be based on the HCFA Market Basket Index forecasts published by the HCFA Regional Office for the quarter ending in September. The inflation factor used is taken from the Excluded Hospital Input Price Index category. Arkansas Medicaid will review the per diem rate annually and adjust the rate, if necessary, based on the provider's unaudited cost report, and the annual inflation factor.

SUPERSEDES: TN- AR 95-24 (pg. 5b)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APPV'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AK 02-09</u>	

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT  
MEDICAL ASSISTANCE PROGRAM  
STATE ARKANSAS

ATTACHMENT 4.19-B  
Page 5b

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES -  
OTHER TYPES OF CARE

Revised: April 1, 2002

14. Services for individuals age 65 or older in institutions for mental diseases.

a. Inpatient hospital services

Not provided.

b. Nursing facility services

Not provided.

SUPERSEDES: TN- AR 95-01 (pg. 5c)

STATE <u>Arkansas</u>	A
DATE REC'D <u>03-18-02</u>	
DATE APP'D <u>04-15-02</u>	
DATE EFF <u>04-01-02</u>	
HCFA 179 <u>AR 02-09</u>	



**DEPARTMENT OF HEALTH & HUMAN SERVICES  
Centers for Medicare & Medicaid Services**

**Calvin G. Cline**

**Associate Regional Administrator, Medicaid and State Operations**

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Fax (214) 767-0270

April 15, 2002

Our Reference: SPA-AR-02-09

Mr. Ray Hanley, Director  
Division of Medical Services – Slot 1103  
Arkansas Department of Human Services  
Post Office Box 1437  
Little Rock, Arkansas 72203-1437

Dear Mr. Hanley:

Enclosed is a copy of the HCFA-179 form referencing Transmittal Number AR-02-09 and dated March 18, 2002. The State Plan is being amended to move medical supplies and equipment items from the Prosthetics category to the Home Health category as specified per Dallas Regional letter dated September 2, 1999 referencing ME-17-0-1 and ME-41-5-1.

The amendment has been approved and will be incorporated into the official Arkansas State Plan effective April 1, 2002. If you have any questions, please call J. P. Peters of my staff. Ms. Peters may be reached by calling (214) 767-2628 or by E-mail at [jpeters@cms.hhs.gov](mailto:jpeters@cms.hhs.gov).

Sincerely,

Calvin G. Cline  
Associate Regional Administrator  
Division of Medicaid and State Operations

Enclosure

cc: Elliott Weisman, CMSO

